SUPREME COURT, U.S.
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No. _____

IN THE SUPREME COURT OF THE UNITED STATES

ELMER and NANCY TRIVETTE, as Co-Administrators of the Estate of the late Randy James Trivette, and Nancy Trivette, Individually, PETITIONERS,

versus

NORTH CAROLINA BAPTIST HOSPITALS, INC., RESPONDENT

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NORTH CAROLINA

PETITION FOR WRIT OF CERTIORARI

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10 pp

QUESTIONS PRESENTED

I. WHETHER THE RESPONDENT HOSPITAL PROVIDED PETITIONERS' INTESTATE AN "APPROPRIATE" MEDICAL SCREENING EXAMINATION AS REQUIRED BY THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA), 42 U.S.C. § 1395dd (SUPP. 1998).

II. WHETHER THE RESPONDENT HOSPITAL "STABILIZED" PETITIONERS' INTESTATE'S EMERGENCY MEDICAL CONDITION BEFORE DISCHARGING HIM, AS REQUIRED BY THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA), 42 U.S.C. § 1395dd(a) and (b) (SUPP. 1998).

III. WHETHER -- UNDER EMTALA -- PETITIONERS WERE ENTITLED TO A REASONABLE OPPORTUNITY FOR PRE-TRIAL DISCOVERY AS TO WHETHER THE DECEDENT WAS TREATED DIFFERENTLY THAN OTHER PATIENTS PERCEIVED TO HAVE THE SAME CONDITION, PRIOR TO GRANTING RESPONDENT'S MOTION FOR SUMMARY JUDGMENT.

IV. WHETHER AN OTHERWISE VALID EMTALA ACTION IS SUBJECT TO DISMISSAL SIMPLY BECAUSE THE RESPONDENT HOSPITAL'S FAILURE TO SCREEN MAY HAVE INVOLVED SOME DEGREE OF MEDICAL MALPRACTICE.

LIST OF PARTIES

The Caption contains the names of all parties to the proceedings in this litigation.

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IN THE SUPREME COURT OF THE UNITED STATES

ELMER and NANCY TRIVETTE, as Co-Administrators of the Estate of the late Randy James Trivette, and Nancy Trivette, Individually, PETITIONERS,

versus

NORTH CAROLINA BAPTIST HOSPITALS, INC., RESPONDENT

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NORTH CAROLINA

Elmer and Nancy Trivette, respectfully, petition for a writ of certiorari to review the opinion of the North Carolina Supreme Court, filed on 9 April 1999.

OPINIONS BELOW

The opinion of the North Carolina Supreme Court, which affirmed *per curiam* the opinion of the North Carolina Court of Appeals and which Elmer and Nancy Trivette ("Petitioners") ask this Court to review, is reprinted and attached hereto as Appendix A, pp. 20-22. The opinion of the North Carolina Court of Appeals, which was subsequently affirmed by the North Carolina Supreme Court, is reported at 131 N.C.App 73, 507 S.E.2d 48 (1998) and is reprinted and attached hereto as Appendix B, pp. 23-32. The Judgment of the North Carolina Superior Court is unreported but is reprinted and attached hereto as Appendix C, pp. 33-35.

JURISDICTION

The opinion of the North Carolina Supreme Court was filed on 9 April 1999, affirming the judgment of the North Carolina Court of Appeals which upheld the trial court's grant of summary judgment in favor of the Respondents. The jurisdiction of this Court is invoked pursuant to 28 U.S.C.A. § 1254.

STATUTORY PROVISIONS INVOLVED

The statute involved in this case is the "Emergency Medical Treatment and Active Labor Act," 42 U.S.C. § 1395dd, a copy of which is attached hereto as Appendix D, pp. 36-46.

STATEMENT OF THE CASE

This action arises out of North Carolina Baptist Hospitals, Inc.'s ("Hospital" or "Respondent Hospital") failure to treat, screen, and stabilize Randy Trivette ("Randy") when he arrived at the Hospital's emergency room late in the evening on May 2, 1996. Randy subsequently died on October 9, 1996. On December 3, 1996, Elmer and Nancy Trivette ("Petitioners") were qualified as Administrators of their late son's estate. Petitioners filed this lawsuit on July 6, 1997, alleging that the Respondent Hospital violated the requirements of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1993) ("EMTALA" or "COBRA") and that, as a result, Petitioners' intestate suffered damages in excess of $10,000. Specifically, Petitioners alleged that Respondent Hospital violated EMTALA by (1) failing to conduct an appropriate medical screening examination of Randy and (2) discharging Randy before they had stabilized his emergency condition. (A copy of the Complaint is reprinted and attached hereto as Appendix E, pp. 47-52.)

Randy Trivette was born on January 10, 1969. He had been a profoundly disabled, total care patient since he

contracted meningitis/encephalitis when he was approximately six weeks old. Randy also suffered from both severe mental retardation and cerebral palsy. On May 2, 1996, at approximately 9 p.m., Randy was taken by ambulance to the Respondent Hospital in Winston-Salem, North Carolina. Both of Randy's parents were with him when he arrived. At the time he presented, Randy's chief complaints were frequent vomiting (hyperemesis) of his own blood, choking after bottle feeding and resulting inability to take food or water, extreme pallor and limpness, and a marked decrease in mental status. Randy was unconscious when he was admitted.

In the emergency room, Randy was given an "examination" by two of the Hospital's medical professionals. The results showed the following: (1) the patient was unresponsive to painful stimuli; (2) his pupils were fully dilated 5+ in both eyes; (3) his capillary refill was severely delayed 3-4 seconds; (4) he had hypoactive (subnormal) bowel sounds; (5) his hemoglobin was 7.0 (normal is 14.0-18.0); (6) his hematocrit was 24.1 (normal is 40-52); (7) his white blood cell count was elevated 8,500 (normal is 1,600-7,300); (8) his red blood cells were teardrop shaped instead of round; and (9) his blood iron was 6 (normal is 40-160). Randy was unconscious and unresponsive. His skin was colorless, and Randy was limp and lifeless. Randy's white blood cell count was elevated, his iron levels woefully low and his eyes fully dilated. These are classic symptoms of gastrointestinal bleeding, which itself requires immediate medical intervention to prevent serious damage to patient's health. Such internal bleeding also indicates a more serious medical condition.

Based on Randy's symptoms and the test results set forth above, Respondent's own emergency room personnel recommended that Randy be admitted to the hospital so that an EEG and a neurology consult could be administered. Despite the recommendations made by the Respondent Hospital's own emergency room personnel, no one administered the EEG or conducted the neurological consult. As discussed in greater

detail below, Randy was discharged early the next morning. Less than twelve hours after his discharge, Randy was taken by ambulance to Forsyth Memorial Hospital ("Forsyth"), where these basic diagnostic tests were given as part of Randy's initial screening examination. These tests, recommended but not given at the Respondent Hospital, revealed Randy's emergency medical condition: a cerebral hemorrhage.

Petitioners also alleged that Respondent Hospital violated EMTALA by failing to stabilize Randy's emergency medical condition before discharging him. Randy was admitted late on the night of May 2, 1996, and discharged early in the morning of May 3, 1996. Randy was discharged in virtually the same condition in which he was admitted. When he was discharged, Randy was still unconscious, still unable to take food or drink, still pale and colorless, limp and lifeless, and still vomiting his own blood. Randy's discharge record contains no indication that Randy ever became conscious or responsive to painful stimuli while at Respondent Hospital.

In the hours after his discharge, Randy's condition steadily deteriorated. Finally, approximately twelve hours after Randy's discharge from Respondent Hospital, he was again taken by ambulance to another emergency room. This time Randy's parents demanded that he be taken to Forsyth Memorial Hospital, another local hospital. Randy was admitted to Forsyth at approximately 11:30 p.m. on May 3, 1996. When Randy presented at Forsyth, only twelve hours after his discharge from Defendant Hospital, Randy was still suffering from the same afflictions and complaints as when he was admitted to Respondent Hospital late the previous night, as well as when he was discharged earlier that same morning. As the test results indicate, however, Randy's condition had deteriorated in the twelve hours after his discharge from the Respondent Hospital. (*Id.*) Blood was present not only in his vomit, but also was now present in his stool. The diagnostic "screening examination" performed at Forsyth on May 4, 1996, confirmed the gastrointestinal bleeding and also revealed that Randy had in

fact suffered a cerebral hemorrhage. Randy was immediately transfused with three units of packed blood cells and IVs for hydration and oxygen support.

Approximately ten days after he was admitted to Forsyth, Randy regained consciousness. He stayed at Forsyth for approximately thirty-one days until he was discharged in early June. On October 9, 1996, Randy died. Petitioners Elmer and Nancy Trivette qualified as Administrators of their late son's estate on December 3, 1996.

On July 6, 1997, Petitioners filed this lawsuit alleging that Respondent Hospital had violated 42 U.S.C. 1395dd. In their Answer, Respondent Hospital denied the allegation that it had violated EMTALA and, shortly thereafter, moved to dismiss the Petitioners' cause of action under N.C.R.CIV.APP. 12(b)(6) for an alleged failure to state a cause of action. (A copy of the Answer is reprinted and attached hereto as Appendix F, pp. 53-57.) In support of their motion to dismiss, Respondents filed the affidavits of Drs. Ruby Moniago and Timothy Pennell. (A copy of the Affidavit of Dr. Ruby Moniago is reprinted and attached hereto as Appendix G, pp. 58-60.) Petitioners were, as a result, required to file the affidavit of Elmer Trivette, because under the North Carolina Rules of Civil Procedure a party may not rest on the pleadings if materials outside the pleadings are considered by the court. (A copy of the Affidavit of Elmer Trivette is reprinted and attached hereto as Appendix H, pp. 61-63.) Because the trial court considered the affidavits submitted by the parties, it converted the motion to dismiss into a motion for summary judgment. Although no discovery had been conducted before the hearing on this motion, the trial court granted summary judgment for

the Defendant on October 7, 1997.[1] On October 23, 1997, Petitioners appealed to the North Carolina Court of Appeals,[2] which affirmed the holding of the trial court by opinion filed October 6, 1998. *Trivette v. North Carolina Baptist Hospital, Inc.*, 131 N.C.App 73, 507 S.E.2d 48 (1998). Petitioners served their Notice of Appeal along with their Petition for Discretionary Review, on October 13, 1998.

As a result of Judge Green's dissent at the Court of Appeals, the North Carolina Supreme Court accepted review as of right on December 3, 1998, on the issue of whether Petitioners had raised a genuine issue of material fact on the question of whether Randy had received an "appropriate" medical screening. The North Carolina Supreme Court also

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[1] In light of the Court of Appeals finding that "plaintiff [sic] failed to produce any evidence of disparate treatment by defendant hospital toward Randy during this initial screening examination," *Trivette*, 131 N.C.App at 78, 507 S.E.2d at 52, it is important to note that Petitioners were never permitted to take any discovery in this matter. Thus the important issues of first impression before this Court are based solely on a bare bones record.

[2] On appeal to the Court of Appeals Petitioners contended that the trial court erred when it concluded that there were no genuine issues of material fact in this case, and that Respondents were entitled to judgment under the holding in *Vickers v. Nash County General Hospital, Inc.*, 78 F.3d 139 (4th Cir. 1996). Petitioners contended that they had forecast sufficient evidence to show that genuine issues of material fact existed in this action and that this evidence could - when considered in its most favorable light - justify a rational trier of fact's conclusion that the Hospital had indeed violated EMTALA. Specifically, Petitioners contended that genuine questions of fact exist with respect to (1) whether Randy Trivette received an "appropriate" screening for an emergency medical condition and (2) whether Randy Trivette's condition was "stabilized" before he was released from the Hospital's care, the very issues which are now presented to this Court for review.

granted discretionary review on the issue of whether Randy had been "stabilized" prior to his discharge from the Hospital. After oral argument the North Carolina Supreme Court affirmed *per curiam* the decision of both the Court of Appeals and the trial court.

Petitioners now file this Petition for Writ of Certiorari to the United States Supreme Court to review the North Carolina Supreme Court's interpretation of federal law in this matter.

REASONS FOR GRANTING THE PETITION

EMTALA places two requirements on a hospital when a patient presents for treatment at its emergency room. First, the statute requires that "the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists." 42 U.S.C. § 1395dd(a). Second, EMTALA requires that "[i]f any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either (A) . . . for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility. 42 U.S.C. § 1395dd(b)(1)(A) and (B). This case presents questions of first impression for this Court on both the "appropriate" screening and the "stabilization" requirement.

I. The Court Should Grant The Petition For Writ Of Certiorari Because This Case Presents The Court With Its First Opportunity To Define "Appropriate" As Understood By EMTALA'S Medical Screening Examination Requirement.

The instant case presents the Court with its first opportunity to define "appropriate" within the context of the medical screening requirement of EMTALA. As the circuit courts have recognized, "EMTALA requires an appropriate medical screening, but does not explain what constitutes one. The adjectival phrase is not self-defining." *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir.1995); *See also, Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir.1990) ("'Appropriate' is one of the most wonderful weasel words in the dictionary . . . . Who after all, can be found to stand up for 'inappropriate' treatment or actions of any sort?")

In an effort to draw a bright line between EMTALA claims and state medical malpractice claims, the circuit courts have concluded that "appropriate" means a screening which is applied uniformly to all those who present with substantially similar complaints. *Correa v. Hospital San Francisco*, 69 F.3d 1184 (1st Cir. 1995); *Baber v. Hospital Corp. of America*, 977 F.2d 872, 879 (4th Cir.1992); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C.Cir.1991). The federal circuit courts and now the North Carolina Supreme Court, therefore, have generally agreed that a hospital violates EMTALA only where it refuses to follow its own standard screening practice in a particular instance. EMTALA itself, however, does not impose any such limitation on the definition of "appropriate." As a practical matter, the standard generally accepted by the circuit courts has imposed a high obstacle for claimants seeking to recover under EMTALA.

In a further effort to distinguish EMTALA from medical malpractice claims arising under state law, the federal circuit

courts have emphasized that the treatment of patients in emergency settings requires the "exercise of medical training and judgment" and that "hospital personnel must assess a patient's signs and symptoms and use their informed judgment to determine whether a critical condition exists." *Baber*, 977 F.2d at 879. The circuit courts have routinely held that EMTALA does not provide a remedy where the only contention is predicated upon the defendant's failure of judgment or diagnosis. *Id.*

This case presents a particularly compelling example of the difficulty that the "appropriate" standard causes when it is read as a synonym for "uniformly applied."[3] Petitioners here did not allege that Hospital personnel failed in their exercise of medical judgment and thereby misdiagnosed Randy Trivette. To the contrary, Petitioners alleged that the emergency room physicians properly exercised their medical judgment when they admitted Randy into the hospital and recommended an EEG and a neurology consult to detect a possible brain injury. The gravaman of Petitioners' complaint is that Randy did not receive an "appropriate" medical screening because the recommended diagnostic tests were never administered,

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[3] Because this action was dismissed on a 12(b)(6) motion, converted into a motion for summary judgment by the court's consideration of three affidavits, Petitioners were never afforded an opportunity to begin the discovery process to determine whether or not the hospital deviated from its standard screening procedure for patient's with similar complaints as Randy Trivette. *See* discussion, *infra*, pp. 17-18.

not that Randy was misdiagnosed.[4] Petitioners supported this contention with the undisputed facts: (1) Randy was admitted into the Hospital so that certain basic diagnostic screening tests could be administered; (2) these tests had been recommended by two of the hospital's own emergency room physicians; (3) although the Hospital admitted Randy, it never administered the recommended screening tests; (4) less than twelve hours after Randy's discharge from the Respondent Hospital, the same screening tests, which had been recommended at the Hospital, were administered at another area hospital upon Randy's presentation at its emergency room; and (5) these tests when administered, revealed that Randy had suffered a cerebral hemorrhage.

In spite of the above, the North Carolina Supreme Court affirmed the Court of Appeals' opinion that the Hospital discharged its EMTALA duty to provide Randy an

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[4] Petitioners have consistently maintained that whether the hospital knew that Randy's emergency medical condition was a cerebral hemorrhage or not, Randy was self-evidently in an emergency medical condition both when he was admitted and when he was discharged less than a day later. For instance, when Randy presented he could not take food or water. Less than twelve hours later, when Randy was discharged he had never regained his ability to take food or water. When a patient presents and is discharged in an obvious emergency medical condition (unable to eat or drink), a Hospital should not be able to escape liability by asserting that it was not aware of the precise emergency medical condition which the patient had. EMTALA requires only that the hospital recognize that the patient is in an emergency medical condition. In this case, Petitioners raised a question of fact as to whether a patient in Randy's condition was suffering an emergency medical condition of which the hospital knew or should have been aware of. Furthermore, the hospital did not know the precise nature of Randy's emergency medical condition because it failed to administer the very screening examinations recommended by its own emergency room physicians. *See* discussion, *infra*, pp. 12-16.

"appropriate" medical screening when "the attending physician performed a battery of tests and admitted the patient to remain in the hospital overnight. These actions constitute an "appropriate screening examination." *Trivette*, 131 N.C.App at 78, 507 S.E.2d at 52, affirmed *per curiam* by the North Carolina Supreme Court. Both the Court of Appeals and the Supreme Court were satisfied that Randy's screening was "appropriate even though it noted that the "appellant correctly points out that in this case, unlike in the cases mentioned, the physician actually recommended further testing that was never performed." *Trivette*, 131 N.C.App. at 78, 507 S.E.2d at 52.

The decision of the North Carolina Supreme Court conflicts with the Sixth Circuit's warning that "[h]ospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient." *Thorton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir.1990). This admonition is especially compelling in light of the uncontradicted evidence that Randy was discharged - - in the same condition in which he was admitted - less than twelve hours after he presented at the Respondent Hospital.

This equation of "appropriate" with "uniform" has been criticized by commentators and raised some concerns in the circuit courts themselves. The fear is that such a standard provides a perverse incentive for hospitals to lower their initial screening standards. One author has criticized defining "appropriate" in terms of "uniformity" because "hospitals could theoretically avoid liability by providing very cursory and substandard screenings to all patients, which might enable a doctor to ignore an emergency medical condition." Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the COBRA's Fangs, 61 N.Y.U.L.Rev. 1186 (1986); *Baber v. Hospital Corporation of America*, 977 F.2d 872 (4th Cir.1992)(raising the possibility that a hospital's standard screening procedure could be so low as to constitute a violation of the "appropriate" standard) (dicta); *Trivette*, 131 N.C.App. at

76, 507 S.E.2d at 51, n. 1 ("There is still some debate whether a hospital's screening standard can be so low as to constitute a "failure to treat," and hence an EMTALA violation.")

The Court should grant the Petition for Writ of Certiorari because this case presents the Court with its first opportunity to provide guidance as to the meaning of "appropriate" under EMTALA's medical screening provision. This question is an important one because it impacts the pleading and proof requirements for every EMTALA claimant. If a hospital can discharge its duty to provide an "appropriate" medical screening examination for an emergency medical condition by merely admitting a patient and suggesting a "screening" procedure ("we should administer these tests... "), rather than by actually administering the tests, then the EMTALA "screening" requirement would be substantially weakened, if not destroyed. This issue is critical for every EMTALA claimant as well as every individual who seeks medical care in an emergency room.

II. The Court Should Grant The Petition For Writ Of Certiorari Because This Case Permits The Court To Define For The First Time The Knowledge Required To Trigger The "Stabilization" Requirement.

In addition to its requirement that hospitals conduct an "appropriate" medical screening examination, EMTALA forbids a hospital from transferring or discharging a patient when he "comes to a hospital and the hospital determines that the individual has an emergency medical condition." 42 U.S.C. § 1395dd(b)(1).

The federal circuit courts have generally interpreted this provision to mean that a hospital must have actual knowledge of the existence of an emergency medical condition before the stabilization requirement is triggered. *Thorton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir.1990); *Urban v. Central Kansas Medical Center*, 43 F.3d 523 (10th Cir.1994);

Baber v. Hospital Corporation of America, 977 F.2d 872 (4th Cir.1992); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C.Cir.1991). In order to survive pre-trial dispositive motions, therefore, a claimant must plead and forecast evidence sufficient to show that the hospital had knowledge that the patient was suffering from an emergency medical condition.[5]

The Court should grant this Writ of Certiorari because this case enables the Court to decide for the first time whether or not EMTALA's stabilization requirement can be triggered by a showing that a hospital had constructive knowledge of the presence of an emergency medical condition. This case presents a compelling fact pattern for two reasons. First, the Respondent Hospital's alleged lack of knowledge of the emergency medical condition stems not from misdiagnosis but from the Hospital's failure to administer screening tests

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[5] The cases are silent as to whether the plaintiff must show that the hospital knew the particular emergency medical condition suffered by the plaintiff or if it is sufficient to show that the hospital knew (or had reason to know) that the plaintiff suffered from an unidentified emergency medical condition. This is relevant in the instant case because the hospital has successfully defended liability under the stabilization prong of EMTALA by arguing that it did not know that Randy had suffered from a cerebral hemorrhage. Nevertheless, when Randy presented at the hospital, among his other symptoms, he was unable to take food and drink. The pleadings and the affidavit of Elmer Trivette, both of which must be taken as true for purposes of dispositive pre-trial motions, indicate that Randy was in the identical condition when he was discharged as when he was admitted. Most significantly, Randy was discharged even though he was still unconscious and unable to take food or drink. This alone raises a substantial issue under EMTALA: whether a hospital can successfully defend an EMTALA action by arguing that it did not know the precise nature of a patient's emergency medical condition, even though the patient was clearly in a life-threatening condition (unconscious, vomiting his own blood, and unable to eat or drink).

recommended by its own physicians. The uncontraverted evidence in the record is that two physicians at the Respondent Hospital recommended that Randy be admitted so that certain screening tests could be conducted for possible brain injury (an EEG and a neurology consult). The record is clear that, although Randy was admitted to the Hospital, these tests were never administered. Less than twenty-four hours after Randy's discharge, the same tests which were recommended but not given at the Respondent Hospital, were administered at another local hospital. The tests revealed Randy's emergency medical condition: a cerebral hemorrhage.

The second reason the facts of this case present a compelling vehicle for the Court to analyze the knowledge requirement under EMTALA is that the emergency nature of Randy's medical condition was self-evident. Under EMTALA, a condition is considered an emergency medical condition when it "manifests itself by acute symptoms of sufficient severity (including pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." 42 U.S.C. § 1995dd(e)(1)(A). When Randy presented at the Respondent Hospital his chief complaints were frequent vomiting of his own blood, choking when eating and drinking which resulted in an inability to take food or drink, extreme pallor and limpness, and a marked decrease in mental status. Randy was unconscious throughout his brief stay at the Respondent Hospital.

The Hospital has to date successfully defended this action by arguing that it had no duty to stabilize Randy Trivette because it was unaware that he was suffering from an "emergency medical condition." *See Trivette v. North Carolina Baptist Hospitals, Inc.*, 131 N.C.App. 73, 507 S.E.2d 48 (1998). Yet, it strains credulity for a trained medical professional to assert that he did not realize that his patient's health was in "serious jeopardy" where the patient was

unconscious, vomiting his own blood, unable to take food or drink, extremely pale, with a limp and lifeless body.

This issue is critical in the instant case because Petitioners forecast sufficient evidence to demonstrate that the Respondent Hospital discharged Randy before it had stabilized his emergency medical condition. *See* 42 U.S.C. 1395dd(b). The uncontradicted evidence is that Randy Trivette was discharged in an identical condition as when he presented at the Hospital.[6] It is also uncontradicted that Randy's condition materially deteriorated in the approximately twelve hours between his discharge from the Respondent Hospital and his arrival at the emergency room of another local hospital. Under EMTALA, to stabilize means 'to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer [or discharge] of the individual from a facility." 42 U.S.C. § 1395(e)(3)(A). For purposes of pre-trial dispositive motions, Petitioners properly pleaded the failure of the hospital to stabilize Randy Trivette's emergency medical condition.

This case presents a unique opportunity for the Court either to accept, or categorically reject, a constructive knowledge trigger of the "stabilization" requirement under EMTALA. This is an important issue for EMTALA claimants and for public policy because if the North Carolina decision stands, hospitals will employ the following perverse syllogism to escape their EMTALA duties and to depress the quality of medical care in the nation. A hospital will have successfully argued: we had no duty to stabilize the patient because we did not know he was suffering from an emergency medical condition. We did not know the patient was suffering from an

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[6] Furthermore, because this action was disposed of on a 12(b)(6) motion, converted into a summary judgment motion, these allegations must be considered as true. N.C.R.Civ.P. 12(b)(6) and 56.

emergency medical condition because we did not administer the screening tests recommended by our own physicians. But we are not liable for failing to conduct an "appropriate" medical screening because we admitted the patient into the hospital to conduct certain screening tests, even though we never gave the recommended tests, which would have discovered the emergency medical condition.

This argument, which has proved successful to date, mocks the Sixth Circuit's warning that "[h]ospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging the patient. Emergency care must be given until the patient's emergency medical condition is stabilized." *Thorton v. Southwest Detroit Hospital*, 895 F.2d 1131 (1990); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir.1990) ("a discharge that to the knowledge of those conducting it left a patient with an 'emergency medical condition' in an unstable condition would be actionable.")

If a hospital is permitted to escape liability by simply asserting that it did not discover the emergency medical condition, EMTALA will create an incentive for hospitals to lower their standard patient screening procedures, even to the point of refusing to administer diagnostic tests recommended by their own physicians. This "race to the bottom" cannot be consistent with Congress' intent of promoting the quality of health care in the country.

III. The Court Should Grant The Petition For Writ Of Certiorari Because It Has Recently Accepted Another EMTALA Action And By Hearing Both Cases Could Speak Definitely As To The Court's Interpretation Of This Federal Statute.

The Court has recently accepted another EMTALA case for review, *Roberts v. Galen of Virginia*, 111 F.3d 405 (6th Cir. 1997). The presence of both cases on the docket provides this

Court an opportunity to provide more complete guidance to lower court's on the scope and basis of a hospital's liability under EMTALA.

The instant case raises the threshold issues of the requirements of proof and pleading to successfully survive pre-trial dispositive motions. *Roberts*, on the other hand, deals solely with the issue of whether a claimant must prove that a hospital discharged the patient with an improper motive. *Id.* Although the cases involve distinct issues, they both deal with the fundamental question of what a claimant must prove in order to bring a successful EMTALA claim. The federal courts have struggled to keep EMTALA from becoming a federal substitute for medical malpractice statute. In so doing, however, as the instant case demonstrates, EMTALA is gradually being turned into a dead letter, as the typical fate of an EMTALA claimant is dismissal for failure to state a claim. See *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C.Cir.1991) (affirming dismissal on summary judgment); *Roberts v. Galen of Virginia*, 111 F.3d 405 (6th Cir.1997)(affirming dismissal on summary judgment); *Urban v. Central Kansas Medical Center*, 43 F.3d 523 (10th Cir.1994)(affirming dismissal on summary judgment); *Baber v. Hospital Corporation of America*, 977 F.2d 872 (4th Cir.1992)(affirming dismissal on 12(b)(6) motion converted to summary judgment by the submission of affidavits and deposition testimony); *Thorton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir.1990)(affirming dismissal on summary judgment).

IV. The Court Should Grant The Petition For Writ Of Certiorari Because The North Carolina Courts Should Not Have Dismissed Plaintiffs' Action Prior To Initiation Of The Discovery Process.

This Court should grant the Petition for Writ of Certiorari because the North Carolina state courts erred in dismissing this action under 12(b)(6) motion, converted into a motion for summary judgment by the submission of the

affidavits of Dr. Timothy Pennell, Dr. Ruby Moniago, and Elmer Trivette. The North Carolina Supreme Court and the Court of Appeals affirmed the trial court's dismissal of this action not only on the grounds that the examination Randy received was "appropriate" because some tests were given and he was admitted into the hospital, but also because "plaintiff failed to produce any evidence of disparate treatment by the defendant Hospital toward Randy during the initial screening examination." *Trivette*, 131 N.C.App. at 78, 507 S.E.2d at 52.

There is no question that Petitioners properly pleaded disparate treatment, which would have permitted them to survive a simple 12(b)(6) motion. In paragraph 9 of the Complaint, Petitioners alleged: . . . "because he was severely disabled, Randy received disparate treatment from the Defendant Hospital which was different than the care provided other patients perceived to have the same condition." (R. at 3.) The Court, then, dismissed Petitioners' claim, after converting the motion to dismiss into a motion for summary judgment and holding that they had not produced any evidence to support their allegation of disparate treatment. *Trivette*, 131 N.C.App. at 78, 507 S.E.2d at 52. Petitioners, however, were never afforded an opportunity to engage in the discovery process. Petitioners, as a result, never had an opportunity to determine whether or not the Hospital had followed its regular screening practice for treating patients in a substantially similar condition as Randy.

As the dissent below recognized, a rational trier of fact could conclude that "there is uncontradicted evidence that Randy [Trivette, the deceased] did not receive certain tests recommended by the emergency room doctor," and that failure to administer those tests "presents a genuine issue of fact as to whether Randy was provided an 'appropriate screening examination' as required by . . . EMTALA." *Trivette*, 131 N.C.App. at 79, 507 S.E.2d at 53.

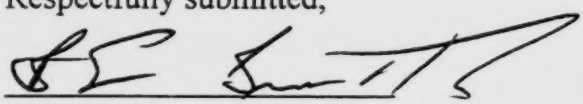
V. The Court Should Grant The Writ Of Certiorari Because The Questions Presented Are Important.

This case raises extremely important issues concerning the scope of EMTALA. The purpose of EMTALA was to provide an "adequate first response to a medical crisis" for all patients and to "send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress." *Baber*, 977 F.2d at 880, *quoting* 131 Cong. Rec. S13904 (Oct. 23, 1985)(statement of Sen. Durenberger). If a medical screening examination can be "appropriate," even where the hospital refuses to administer basic diagnostic screening tests, recommended by its own physicians, when indigent, handicapped Americans seek medical care in their emergency rooms, then EMTALA will be substantially weakened. If hospitals can then discharge such patients only hours later in the identical condition, then EMTALA will effectively be a dead letter.

CONCLUSION

For the above-mentioned reasons, the Petition for Writ of Certiorari should be granted.

Respectfully submitted,



B. Ervin Brown II
Counsel for Petitioners

OF COUNSEL:

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APPENDIX A

Opinion of the North Carolina Supreme Court

IN THE SUPREME COURT OF NORTH CAROLINA

No. 448A98

ELMER TRIVETTE and NANCY TRIVETTE, as
Co-Administrators or the Estate of Randy James Trivette,

v.

NORTH CAROLINA BAPTIST HOSPITALS, INC.,

FILED
APR 9, 1999
IN THE OFFICE OF
CLERK SUPREME COURT
OF NORTH CAROLINA

Appeal pursuant to N.C.G.S. § 7A-30(2) from the decision of the divided panel of the Court of Appeals, ___ N.C.App. ____, 507 S.E.2d 48 (1988), affirming an order of summary judgment entered for defendant by Steelman, J., on 8 October 1997 in Superior Court, Forsyth County. On 3 December 1998, the Supreme Court granted discretionary review of the additional issues. Heard in the Supreme Court 9 March 1999.

Moore & Brown, by B. Ervin Brown II and James S. Gibbs, for plaintiff-appellants.

Kilpatrick Stockton LLP, by J. Robert Elster and Richard S. Gottlieb, for defendant-appellee.

PER CURIAM.

We affirm the Court of Appeals' majority opinion as to the issue of whether there was an appropriate medical screening examination as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (1994).

Also, we allowed petition for discretionary review as to the additional issue of whether there was a discharge of the patient before stabilization of the medical condition as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd(a) and (b1) (1994). Upon review, we find that review was improvidently allowed.

AFFIRMED IN PART, DISCRETIONARY REVIEW IMPROVIDENTLY ALLOWED IN PART.

APPENDIX B

Opinion of the North Carolina Court of Appeals

ELMER TRIVETTE and NANCY TRIVETTE, as Co-Administrators of the late Randy James Trivette, and Nancy Trivette, Individually. Plaintiffs,

vs.

NORTH CAROLINA BAPTIST HOSPITAL, INC., Defendant.

NO. COA97-1557
COURT OF APPEALS OF NORTH CAROLINA
507 S.E.2d 48, 1998 N.C. App. LEXIS 1247

FILED
98 OCT 6 A.M. 7:45
IN THE OFFICE OF
CLERK COURT OF APPEALS
OF NORTH CAROLINA

Appeal by plaintiffs Elmer and Nancy Trivette from summary judgment entered 7 October 1997 by Judge Sanford L. Steelman in Forsyth County Superior Court.

COUNSEL

Moore and Brown, by B. Ervin Brown, II, for the plaintiff-appellants.

Kilpatrick Stockton, by J. Robert Elster, Richard S. Gottlieb, for the defendant-appellee.

JUDGES

WYNN, Judge. Judge WALKER concurs. Judge GREENE dissents in a separate opinion. This opinion was authored and delivered to the Clerk of the North Carolina Court of Appeals by Judge Wynn prior to 1 October 1998.

AUTHOR: WYNN

OPINION

WYNN, Judge.

Plaintiffs' decedent, Randy Trivette, a severely disabled adult, lived under the total care of his parents all of his life. On May 2, 1996, Randy was taken by ambulance to defendant North Carolina Baptist Hospital because of continuous vomiting, choking, limpness, pallor, and a decrease in mental status. Randy was unconscious at the time he was admitted.

Upon arrival at the emergency room, Randy was given a screening examination which included a battery of tests and chest x-rays. The medical screening and accompanying tests showed, inter alia, that his white blood cell count was elevated, his iron levels were low and his eyes were fully dilated. Based on these results, Randy was diagnosed as having a possible seizure, and therefore was admitted to the hospital.

The following morning, Randy's primary care physician determined that Randy's condition had stabilized, and discharged him. Within twelve hours of Randy's discharge, he was taken by ambulance to Forsyth Memorial Hospital where he was diagnosed with gastrointestinal bleeding and a cerebral hemorrhage. Randy stayed at Forsyth hospital for twenty-one days before being discharged. He died approximately four months later.

On July 6, 1997, plaintiffs filed suit against North Carolina Baptist Hospital (hereafter "hospital") alleging violations of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1994) (hereafter "EMTALA"). Specifically, plaintiffs contend that defendant hospital violated EMTALA by: (1) failing to provide Randy with an appropriate medical screening, and (2) by discharging him before stabilizing his medical condition. Defendant hospital answered plaintiffs' complaint, and thereafter motioned for summary judgment. The trial court granted defendant's summary judgment motion by

explicitly relying on the Fourth Circuit's holding in *Vickers v. Nash County General Hosp., Inc.*, 78 F.3d 139 (4th Cir. 1996). We affirm.

I.

Summary judgment is appropriate "if the pleadings, depositions, interrogatories, and admissions on file, together with any affidavits, show there is no genuine issue as to any material fact and that a party is entitled to judgment as a matter of law." *Johnson v. Phoenix Mutual Life Ins. Co.*, 300 N.C. 247, 252, 266 S.E.2d 610, 615 (1980). Summary judgment is proper where it appears that even if the plaintiff's facts as alleged are true, the law does not provide for recovery. *Lowder v. Lowder*, 68 N.C. App. 505, 506, 315 S.E.2d 520, 521, *disc. rev. denied* 311 N.C. 759, 321 S.E.2d 138 (1984).

In 1986, Congress enacted EMTALA to address the growing problem of "patient dumping" - the practice of refusing to provide emergency medical treatment to patients unable to pay, or transferring such patients before their emergency conditions are stabilized. *Vickers v. Nash General Hosp. Inc.*, 78 F.3d 139, 142 (4th Cir. 1996). To prevent patient dumping, EMTALA imposes upon hospitals two principal obligations: (1) when an individual seeks treatment in an emergency room, the hospital must provide for an appropriate medical screening examination, and (2) if the screening examination reveals an "emergency medical condition," the hospital must stabilize that condition before transferring or discharging the patient. 42 U.S.C. §§ 1395dd(a), 1395dd(b)(1) (1993). EMTALA imposes these limited duties upon hospitals with emergency rooms because EMTALA was primarily, if not solely, enacted to deal with the problem of patients being turned away from emergency rooms for non-medical reasons. *Bryan v. Rectors & Visitors of the Univ. of Virginia*, 95 F.3d 349, 351 (4th Cir. 1996). Moreover, these duties are "limited" in a very critical sense: "EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to

provide a federal remedy for misdiagnosis or medical negligence." *Power v. Arlington Hosp. Assn.*, 42 F.3d 851, 856 (4th Cir. 1994) (emphasis added).

In the case sub judice, plaintiffs argue that the trial court improperly granted defendant's summary judgment motion. Specifically, plaintiffs argue that there are genuine issues of material fact with respect to its two claims; first, that defendant hospital failed to provide Randy with an "appropriate" screening examination in violation of § 1395dd(a), and second that defendant hospital discharged Randy before stabilizing his condition in violation of § 1395dd(b)(1).

A.

Under EMTALA's Medical screening requirement, 42 U.S.C. § 1395dd(a), when an individual comes to a hospital emergency room for treatment, the hospital must "provide for an appropriate medical screening examination." EMTALA, however, fails to define the phrase "appropriate medical screening examination" beyond stating that its purpose is to identify "emergency medical conditions." *Power*, 42 F.3d at 856. Nonetheless, numerous courts have consistently interpreted this phrase to only require a hospital to develop a screening examination designed to identify emergency medical conditions, and to apply that screening examination uniformly to all patients with similar complaints. *Id. Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710-11 (4th Cir. 1993); *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879 (4th Cir. 1992). That is, the key requirement under EMTALA's screening provision is uniform treatment among similarly situated patients regardless of their ability to pay. Given the narrow duties imposed under EMTALA's screening requirement, this provision does not guarantee that the screening examination will result in a correct

diagnosis or adequate care.[1] *Baber*, 977 F.2d at 879. Indeed, "questions regarding whether a physician or other hospital personnel failed properly to diagnose or treat a patient's condition are best resolved under existing and developing state negligence and medical malpractice theories of recovery." *Vickers*, 78 F.3d at 142 (citing Baber, 977 F.2d at 880).

Appellants contend that Randy was not provided with an "appropriate screening examination" because certain tests recommended by Randy's emergency room doctor were never given. Appellants contend that because the hospital failed to conduct the recommended tests and procedures, the hospital, in essence, "failed to treat" Randy. We find appellants' argument without merit.

As previously stated, a hospital satisfies EMTALA's screening requirement if it uniformly applies a standard medical screening examination. *Brooks*, 996 F.2d at 713. EMTALA, moreover, recognizes a distinction between an initial screening examination and the adequacy and correctness of subsequent treatment . *Vickers*, 78 F.3d at 143. That is, EMTALA is applicable only to the extent that it requires a hospital emergency room to provide all similarly situated patients with uniform initial screening procedures. Once EMTALA's screening requirements are met, the patient's subsequent diagnosis and medical care become the hospital's legal responsibility. *Bryan*, 95 F.3d at 351. Thus, the legal adequacy

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[1] There is still some debate whether a hospital's screening standard can be so low as to constitute a "failure to treat," and hence constitute an EMTALA violation. *Baber*, 977 F.2d at 879 n.7. Although plaintiffs have raised the "failure to treat" issue, we need not address it because we believe that the defendant hospital, by giving Randy a battery of tests and admitting him to the hospital, had an adequate screening procedure which certainly could not equate to a "failure to treat."

of that diagnosis and subsequent care is governed by state malpractice law, not EMTALA. Id.

In *Vickers*, for example, plaintiff alleged that the defendant hospital violated EMTALA's screening requirement using the following syllogism: decedent arrived at the emergency room with a severe laceration of the head; patients with severe head injuries normally undergo certain tests for intra cranial injury; because decedent did not receive those tests, he received disparate treatment. *Vickers*, 78 F.3d at 143. The Court, however, in ruling against plaintiff noted that the defendant hospital did in fact meet EMTALA's screening requirement because the attending physician repaired the laceration and took some x-rays. *Id.* Although the Court conceded that further tests may have saved the decedent's life, it held that these questions related to improper diagnosis and testing, and thus were the exclusive province of state negligence and malpractice law. *Id.*

Similarly, in *Gerber v. Northwest Hosp. Center, Inc.*, 943 F. Supp. 571 (D. Md. 1996), plaintiff filed suit claiming that the defendant hospital violated EMTALA's screening requirement by not addressing her psychiatric symptoms. Specifically, plaintiff complained that the attending physician should have recognized she was seriously depressed because she repeatedly mentioned that she wanted to kill herself and would rather die than always be ill. *Id.* at 574. The court, after noting that the doctor performed a battery of tests, held for the defendant hospital. *Id.* at 574-75. In so ruling, the court stated that although it was arguable that the physician should have performed more or different tests to reach a different or more comprehensive diagnosis, the physician nonetheless met EMTALA's mandate that he treat all similarly situated patients uniformly during their initial screening examination. *Id.*

Similar to the cases mentioned, appellants in the case sub judice contend that the attending physician should have conducted further testing to determine the nature of Randy's

ailments. The appellant correctly points out that in this case, unlike in the cases mentioned, the physician actually recommended further testing that was never performed. Nonetheless, "the correctness of the treatment that follows the [initial] screening" is an issue exclusively in the province of state negligence and malpractice law. Relevant to the case sub judice is the fact that the attending physician performed a battery of tests and admitted the patient to remain in the hospital overnight. These actions constitute an "appropriate screening examination" for EMTALA purposes.

Additionally, we note that plaintiff failed to produce any evidence of disparate treatment by defendant hospital toward Randy during this initial screening examination. Indeed, defendant hospital performed what it perceived to be all the necessary tests, and as a consequence of the results of those tests, admitted Randy to the hospital for treatment. These actions do not demonstrate conduct which offends EMTALA's primary goal of preventing patients from being turned away from hospital emergency rooms for non-economic reasons. Therefore, we affirm the trial court's granting of summary judgment on the § 1395dd(a) issue.

B.

According to EMTALA's stabilization requirement, when a hospital determines that an individual has an "emergency medical condition," the hospital must "stabilize" that condition before transferring or discharging the individual. 42 U.S.C. § 1395dd(b)(1) (1994). A condition is deemed an "emergency medical condition" when it "manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e). EMTALA's stabilization requirements, however, apply only if the hospital actually

determines that the patient suffers from an emergency medical condition. *Baber*, 977 F.2d at 883 (emphasis added). Indeed, to be liable under EMTALA's stabilization requirement, "a hospital must actually perceive the seriousness of the medical condition and nevertheless fail to stabilize it." *Vickers*, 78 F.3d at 145. Accordingly, a hospital cannot be liable under EMTALA for failing to stabilize conditions it did not perceive, even if the hospital was negligent in not perceiving.

In the case sub judice, plaintiffs allege that defendant hospital violated EMTALA's stabilization requirement by discharging Randy even though he was in exactly the same condition as when he arrived. Plaintiffs argue there is a genuine issue of material fact as to whether Randy's condition was "stabilized" prior to his discharge. In making this argument, plaintiffs note that there is no record that Randy stopped vomiting, that his blood count improved, or that he even regained consciousness. Although this information is relevant to a medical malpractice or negligence claim, it is of little import to the case sub judice.

Defendant hospital, in determining to discharge Randy, concluded that Randy had most likely suffered from a seizure and that his condition had stabilized. There is no evidence that defendant hospital perceived or actually knew of Randy's gastrointestinal bleeding or cerebral hemorrhage. Because the defendant hospital did not perceive or know of this condition, it did not have a duty under EMTALA to stabilize it. Rather, defendant hospital had a duty to stabilize what it perceived to be Randy's emergency medical condition - the seizure. Therefore, when the defendant hospital determined prior to discharging Randy that the seizure no longer seriously jeopardized his health, the defendant hospital met its EMTALA duties. Accordingly, we affirm the trial court's decision to grant summary judgment on this issue.

In conclusion, we find there is no genuine issue as to any material fact, and therefore affirm the trial court's decision to grant summary judgment in this matter.

Affirm.

Judge WALKER concurs.

Judge GREENE dissents in a separate opinion.

This opinion was authored and delivered to the Clerk of the North Carolina Court of Appeals by Judge Wynn prior to 1 October 1998.

DISPOSITION: Affirmed.

DISSENT: GREENE, Judge, dissenting.

In this case, there is uncontradicted evidence that Randy did not receive certain tests recommended by the emergency room doctor. This evidence presents a genuine issue of fact as to whether Randy was provided an "appropriate screening examination," as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (Supp. 1998). I, therefore, would reverse summary judgment for the defendant hospital and remand.

APPENDIX C

Judgment of the Forsyth County,
North Carolina Superior Court

NORTH CAROLINA	GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION
FORSYTH COUNTY	97 CvS 4480
ELMER TRIVETTE and NANCY TRIVETTE, as Co-Administrators or the Estate of Randy James Trivette, Plaintiffs, v. NORTH CAROLINA BAPTIST HOSPITALS, INC., Defendants.	Filed on the 8th day of October 1997 Larry King Deputy Clerk of Forsyth County **JUDGMENT**

THIS MATTER came on for hearing before the undersigned Superior Court Judge Presiding at the October 6, 1997, session of Civil Superior Court for Forsyth County, North Carolina upon the motions of the defendant to dismiss plaintiffs' action under Rule 12(b)(6) and 12(c) of the Rules of Civil Procedure. The plaintiffs were represented by B. Ervin Brown II, and the defendant was represented by Richard S. Gottlieb.

By consent of the parties, the affidavits in this matter were considered by the court, and as a result, under the provisions of Rule 12(b) of the Rules of Civil Procedure, the defendant's 12(b)(6) motion is heard as a motion for Summary Judgment under Rule 56.

Plaintiffs complaint alleges a claim against the defendant under the provisions of 42 U.S.C. 1395dd.

It appearing to the Court that there are no genuine issues as to any material facts, and that defendant is entitled to judgment as a matter of law under the rationale of the case of Vickers v. Nash General Hospital, 78 F.3d 139 (4th Cir. 1996).

IT IS ORDERED:

1. The defendant's motion for Summary Judgment is granted and plaintiffs' action is dismissed with prejudice.

2. The costs of this action are taxed to the plaintiffs.

3. The Clerk of Forsyth County shall mail a copy of this order to the counsel for each of the parties and shall note the date of mailing upon the original of this order.

This the 7th day of October, 1997.

s/ Sanford L. Steelman
Judge Presiding

APPENDIX D

42 U.S.C. § 1395dd
(EMTALA)

42 U.S.C. § 1395dd.

Examination and treatment for emergency medical conditions and women in labor

- (a) Medical screening requirement:
  In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.
- (b) Necessary stabilizing treatment for emergency medical conditions and labor
  - (1) In general
    If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines
    that the individual has an emergency medical condition, the
    hospital must provide either -
    - (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
    - (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.
  - (2) Refusal to consent to treatment
    A hospital is deemed to meet the requirement of

paragraph
(1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

- (3) Refusal to consent to transfer
A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

- (c) Restricting transfers until individual stabilized
  - (1) Rule
  If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless -
    - (A) (i) the individual (or a legally responsible person acting on the

individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

- (ii) a physician (within the meaning of section (1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or
- (iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause
- (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

- (B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.
A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

- (2) Appropriate transfer
An appropriate transfer to a medical facility is a transfer
-

- (A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
- (B) in which the receiving facility -
  - (i) has available space and qualified personnel for the treatment of the individual, and
  - (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;
- (C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;
- (D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and
- (E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

- (d) Enforcement
  - (1) Civil money penalties

- (A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.
- (B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who

  -
    - (i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or
    - (ii) misrepresents an individual's condition or other information, including a hospital's obligations under this
      section, is subject to a civil money

penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and *State health* care programs. The provisions of section 7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

- (C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section (a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

- (2) Civil enforcement
  - (A) Personal harm
    Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.
  - (B) Financial loss to other medical facility Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.
  - (C) Limitations on actions
    No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.
- (3) Consultation with peer review organizations
  In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay

would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

- (e) Definitions
  In this section:
  - (1) The term "emergency medical condition" means -
    - (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -
      - (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
      - (ii) serious impairment to bodily functions, or
      - (iii) serious dysfunction of any bodily organ or part; or
    - (B) with respect to a pregnant women who is having contractions -
      - (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
      - (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.
  - (2) The term "participating hospital" means hospital that has entered into a provider agreement under section of this title.
    - (3) (A) The term "to stabilize" means, with respect to an emergency medical

condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

- (B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

- (4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.
- (5) The term "hospital" includes a critical access hospital (as defined in section (mm)(1) of this title).

- (f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the

requirement directly conflicts with a requirement of this section.

- (g) Nondiscrimination
  A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.
- (h) No delay in examination or treatment
  A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.
- (i) Whistleblower protections
  A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

APPENDIX E

Complaint

NORTH CAROLINA	GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION
FORSYTH COUNTY	97 CvS 4480
ELMER TRIVETTE and NANCY TRIVETTE, as Co-Administrators or the Estate of Randy James Trivette, Plaintiffs, v. NORTH CAROLINA BAPTIST HOSPITALS, INC., Defendants.	FILED 97 JUL 9 P.M. 4:56 Forsyth County, C.S.C.

COMPLAINT

Plaintiffs complaining of the Defendant, allege and say as follows:

I. STATEMENT OF THE CASE

1. This action is brought by Elmer and Nancy Trivette, in their capacity as Co-Administrators of their late son's estate. Plaintiffs allege that North Carolina Baptist Hospitals, Inc. failed to conduct an appropriate medical screening examination on their son, Randy James Trivette, and that the Defendant Hospital discharged their son without first stabilizing his emergency medical condition, in violation of the

requirements of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd, *et seq.* ("EMTALA").

II. PARTIES

2. Plaintiffs Elmer and Nancy Trivette are the parents of the late Randy James Trivette, who died on October 9, 1996. Plaintiffs Elmer and Nancy Trivette are citizens and residents of Yadkin County, North Carolina who qualified as Administrators of their late son's estate on December 3, 1996. (A copy of the Letters of Administration are attached hereto and incorporated herein by reference as Exhibit A.)

3. Upon information and belief, Defendant North Carolina Baptist Hospitals, Inc. (the "Defendant Hospital" or "North Carolina Baptist Hospital" alternately) is a North Carolina corporation operating privately owned hospitals in North Carolina which are organized under the laws of the State of North Carolina, including a hospital and medical care facility located in Winston-Salem, North Carolina.

III. FACTS

4. The deceased Randy James Trivette ("Randy") was born on January 109, 1969, to his natural parents. Elmer and Nancy Trivette. Randy was a profoundly disabled, total care patient maintained under a devoted family support system since contracting meningitis/encephalitis at age six weeks. He suffered from both sever mental retardation and cerebral palsy.

5. At approximately 9:00 p.m. on May 2, 1996, Randy was taken by ambulance to the Defendant Hospital. Both of his parents were present when he arrived. At the time he presented, Randy's chief complaints, as described by his parents, were hyperemesis frequent vomiting); choking after a bottle feeding, and becoming limp, with extreme pallor (in the words of his parents, "looking like death"), and a marked

decrease in mental status. At the time of admission, Randy was unconscious.

6. Upon examination in the emergency room, the blood tests and chest x-rays showed the following abnormal results: the patient was unresponsive to painful stimuli; his pupils were fully dilated 5+ in both eyes; his capillary refill was severely delayed 3-4 seconds; he had hypoactive (subnormal) bowel sounds; his hemoglobin was 7.0 (normal is 14.0-18.0); his hemacrit was 24.1 (normal is 40-52); his white blood cell count was elevated 8,500 (normal is 1,600-7,300); his red blood cells were teardrop shaped instead of round, and his blood iron was 6 (normal is 40-160).

7. Based on Plaintiffs' complaints, as alleged in paragraph 5 above, and the test results referred to in paragraph 7 above, the emergency room physician whom Randy saw at the Defendant Hospital knew that Randy had a serious emergency medical condition, as evidence by his recommendation that Randy be given an appropriate medical screening examination to include at a minimum, an EEG and a neurology consult, and that the same be done as soon as possible.

8. Despite the recommendation made by the emergency room physician at the time of admission that an EEG be administered and a neurology consult be conducted both as part of an appropriate medical screening examination for the symptoms with which Randy presented, the Defendant Hospital at no time administered the EEG nor conducted the neurology consult.

9. As alleged in paragraph 8 above, Randy was profoundly disabled. Upon information and belief, because he was severely disabled, Randy received disparate treatment from the Defendant Hospital which was different than the care provided other patients perceived to have the same condition.

10. The Defendant Hospital failed to stabilize Randy's medical condition before discharging him. In fact, Randy's discharge record makes no mention of Randy having become responsive, or being able to take his bottle for fluids and nutrition, nor do they include any medical decision to administer a blood transfusion for his critically low blood count. After his discharge, Randy James Trivette continued to have hypermesis, which became associated with coffee ground emesis and melena. Some twelve (12) hours after Randy Trivette's discharge from the Defendant Hospital, plaintiffs called 911 and asked that their son be taken to Forsyth Memorial Hospital ("Forsyth"), where he was admitted at approximately 11:30 p.m., May 3, 1996. On arrival at Forsyth, Randy presented with upper gastrointestinal bleeding, and with a hemoglobin of 7.0, hemocrit 25.2. Moreover, his blood pressure was 83/52, his white blood count was up to 14,000, his stool was positive for blood, and he had coffee ground vomit . . . all signs of gastrointestinal bleeding. Diagnostic tests performed at Forsyth on May 4, 1996 confirmed the bleeding, as well as a cerebral hemorrhage. The patient was immediately transfused with three (3) units of packed blood cells, and IV's for hydration and oxygen support. Randy's medical records imply that the brain bleeding caused the severe vomiting prior to admission to the Defendant Hospital.

CAUSE OF ACTION
(VIOLATION OF 42 U.S.C. 1395dd)

11. Plaintiffs hereby re-allege and incorporate herein by reference the allegations contained in paragraphs 1-10 above.

12. Defendant North Carolina Baptist Hospital is, upon information and belief, a "participating hospital" as that term is defined in 42 U.S.C. 1395dd(e).

13. The actions of the Defendant Hospital, as herein alleged, violate the provisions of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C.

1395dd, *et seq.*, by (a) failing to provide the said Randy Trivette with an appropriate medical screening examination, as recommended by its own emergency room physician; (b) by providing different treatment to Randy Trivette than treatment provided other patients at North Carolina Baptist Hospital perceived to have the same medical conditions; and (c) discharging Randy Trivette before his emergency medical condition had stabilized.

14. As a result of the actions of the Defendant Hospital, Plaintiffs' intestate suffered damages in an amount to be determined following trial of this matter, but in no event less than $10,000.

NOW WHEREFORE, Plaintiffs pray the court as follows:

1) That they have and recover of the Defendant North Carolina Baptist Hospitals such damages as allowed by law;

2) That Plaintiffs recover of the Defendant the costs of this action, including reasonable attorneys' fees;

3) That Plaintiffs be granted their right to trial by jury on all issues so triable; and

4) For such other and further relief as the interests of justice may require.

Respectfully submitted, this the 9th day of July, 1997.

s/ B. Ervin Brown II, NCSB No. 558
Martha Marie Eastman, NCSB No 22806
MOORE & BROWN
P.O. Box 20007
1014 West Fifth Street
Winston-Salem, NC 27101-0007

APPENDIX F

Answer

NORTH CAROLINA

FORSYTH COUNTY

GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
NO. 97-CvS-4480

ELMER TRIVETTE and NANCY TRIVETTE, as Co-Administrators of the Estate of the late Randy James Trivette, and Nancy Trivette, Individually,

Plaintiffs,

v.

NORTH CAROLINA BAPTIST HOSPITALS, INC.

Defendant.

ANSWER

FILED
97 SEP 9 P.M. 3:09
Forsyth County, C.S.C.

NOW COMES defendant North Carolina Baptist Hospital, Inc. and answers the Complaint of plaintiffs as follows:

I. STATE OF THE CASE

1. It is admitted that Elmer and Nancy Trivette brought this suit in their capacity as Co-Administrators of their son's estate. Except as admitted, Paragraph No. 1 of the Complaint is denied.

II. PARTIES

2. Upon information and belief, the allegations contained in Paragraph No. 2 of the Complaint are admitted.

3. It is admitted that North Carolina Baptist Hospitals, Inc. is a not-for-profit corporation existing under the

laws of the State of North Carolina and operates health care facilities. Except as admitted, denied.

III. FACTS

4. This defendant lacks knowledge or information sufficient to form a belief as to the truth or falsity of the allegations contained in Paragraph No. 4 of the Complaint, and these allegations are therefore denied.

5. It is admitted that plaintiffs' decedent was taken by ambulance to the North Carolina Baptist Hospital on May 2, 1996. It is averred that the records themselves are the best evidence of the details of his condition. Except as admitted, denied.

6. It is admitted that plaintiffs' decedent was examined in the emergency department and received an appropriate medical screening. It is averred that the records themselves are the best evidence of the details of his condition. Except as admitted, denied.

7. It is admitted that plaintiffs' decedent was examined and diagnostic testing was performed. It is averred that the records themselves are the best evidence of the details of his condition. Except as admitted, denied.

8. Denied as alleged. It is averred that the records themselves are the best evidence of the details of his condition and treatment.

9. It is admitted that Randy James Trivette was profoundly disabled. Except as admitted, denied.

10. Denied. It is admitted that plaintiffs' decedent was admitted from the emergency department to the hospital as a patient of Dr. Wayne Franklin, Randy Trivette's regular treating physician. Dr. Franklin was at all times relevant

employed by Winston-Salem Healthcare, Inc. He has never been an employee of the North Carolina Baptist Hospital, Inc. It is also admitted that on the morning of May 3, 1996, plaintiffs' decedent was examined by Dr. Franklin. Dr. Franklin observed plaintiffs' decedent in a stable condition and ordered the resident on duty, Ruby Moniago, to discharge plaintiffs' decedent from the hospital. It is averred that the records themselves are the best evidence of the details of his condition. Except as admitted, denied.

ALLEGED CAUSE OF ACTION

11. Defendant incorporates herein by reference its answers to Paragraph Nos. 2 through 10 of the Complaint as if fully set forth herein.

12. The allegations contained in Paragraph No. 12 of the Complaint are admitted.

13. The allegations contained in Paragraph No. 13 of the Complaint are denied.

14. The allegations contained in Paragraph No. 14 of the Complaint are denied.

And for a FIRST FURTHER ANSWER AND DEFENSE to the Complaint of the plaintiffs, this defendant, the North Carolina Baptist Hospital, Inc., says and alleges:

1. The Complaint fails to state a claim upon which relief can be granted and therefore should be dismissed pursuant to Rule 12(b)(6) of the North Carolina Rules of Civil Procedure.

And for a SECOND FURTHER ANSWER AND DEFENSE to the Complaint of the plaintiffs, this defendant, the North Carolina Baptist Hospital, Inc., says and alleges:

1. This defendant is entitled to judgment on the pleadings as a matter of law pursuant to Rule 12(c) of the North Carolina Rules of Civil Procedure.

WHEREFORE, this defendant, the North Carolina Baptist Hospitals, Inc., respectfully prays the Court:

1. That the plaintiffs recover nothing of this defendant and that plaintiffs action be dismissed;

2. That the costs of the action be taxed against the plaintiffs;

3. That this action be placed on the jury docket for trial by jury; and

4. For such other and further relief as the Court deems just and proper.

This the 9th day of September, 1997.

s/ Richard S. Gottlieb
J. Robert Elster
Attorneys for Defendant
North Carolina Baptist Hospitals, Inc.

KILPATRICK STOCKTON LLP
1001 West Fourth Street
Winston-Salem, NC 27101-2400
Telephone: (910) 607-7300

APPENDIX G

Affidavit of Dr. Ruby Moniago

NORTH CAROLINA	GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION
FORSYTH COUNTY	97 CvS 4480
ELMER TRIVETTE and NANCY TRIVETTE, as Co-Administrators or the Estate of Randy James Trivette, Plaintiffs, v. NORTH CAROLINA BAPTIST HOSPITALS, INC., Defendants.	**AFFIDAVIT OF RUBY MONIAGO, M.D.** FILED 97 OCT 3 P.M. 4:32 Forsyth County, C.S.C.

1. My name is Dr. Ruby Moniago. I am a medical doctor specializing in the field of pediatric medicine. At the times alleged in the Complaint; I was a senior resident at the North Carolina Baptist Hospitals, Inc. ("NCBH") in Winston-Salem, North Carolina.

2. In the late evening hours of May 2, 1996, Randy Trivette presented to the emergency department of the North Carolina Baptist Hospitals, Inc. After being examined by an emergency room pediatric specialist, Randy was admitted to the pediatric floor by Dr. Robert Williams, a physician with Winston-Salem Health Care, Inc. who was contacted by phone by an emergency department physician. I was the resident on duty when Randy was admitted to the floor. Upon Randy's admittance I, along with Steven Meadows, a third year medical

student, gave Randy another, complete examination. At all times Randy remained in stable condition.

3. During the early morning of May 3, 1996 Randy was examined by his regular, treating physician, Dr. Wayne Franklin. At that time, Dr. Franklin was a physician with Winston-Salem Health Care, Inc. Dr. Franklin had staff privileges at NCBH, and was Randy's treating physician. Dr. Franklin determined that Randy was in stable condition and ordered that he be discharged from NCBH and directed me to write the discharge order. As a resident, I did not have authority to discharge a patient on my own.

4. As one of the physicians who treated Randy, I can attest that he was not "refused treatment" by the Hospital. I also confirm that Randy's attending physician, Dr. Franklin, order that he be discharged.

This the 2d day of October, 1997.

s/ Ruby Moniago, M.D.

Sworn to and subscribed before me,
this the 2 day of October, 1997.

s/ Barbara Reaves
NOTARY PUBLIC

My Commission Expires:

March 13, 2001

APPENDIX H

Affidavit of Elmer Trivette

NORTH CAROLINA

FORSYTH COUNTY

GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
97 CvS 4480

ELMER TRIVETTE and NANCY TRIVETTE, as Co-Administrators or the Estate of Randy James Trivette,	)	
Plaintiffs,	)	**AFFIDAVIT OF ELMER TRIVETTE**
v.	)	
NORTH CAROLINA BAPTIST HOSPITALS, INC.,	)	
Defendants.	)	

NOW COMES the affiant, and being duly sworn, deposes and says as follows:

1. My name is Elmer Trivette and I am the father of the late Randy James Trivette. Together with my wife, I am administrator of our late son's estate.

2. I was present when my son was admitted to North Carolina Baptist Hospital on May 2, 1996. At that time, he was unconscious, throwing up a dark substance which looked like coffee grounds, and looked very pale, like he was dead.

3. I was present at my son's side when Dr. Franklin told us "Randy's going home." I told Dr. Franklin that

something was bad wrong with Randy since he was still unconscious, throwing up the same dark substance he had been throwing up when we took him to the Baptist Hospital (we later learned from the doctors at Forsyth Hospital that this dark substance was blood), and his skin had no color. In short, he showed the same symptoms a when he first went into Baptist Hospital. Nevertheless, Dr. Franklin sent him home. He told me that he had given Randy a prescription for some suppositories, and that if he was not better by Monday, to call and set up an appointment. On the same day we took Randy to Forsyth Memorial Hospital where he remained for approximately 31 days. Ten days elapsed from the time he was discharged from Baptist before Randy ever regained consciousness.

Further the affiant sayeth naught.

s/ Elmer Trivette

Forsyth County
Sworn to me, the undersigned notary public,
commissioned in the State of North Carolina
and County of Stokes, on this the 2nd day of October, 1997.

s/ Hilda Shelton
Notary Public

My commission expires 9/5/2001.